For Debate . . .

Perinatal health services: an immodest proposal

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During the past five years the health and social services available to childbearing women and their families (the perinatal health services) have been under almost constant attack. Why is it that childbirth, "that most creative and joyous of events, should have become in the last few years a battleground, to be fought over by opposing factions whose only common characteristic, seemingly, and yet one which divides them most deeply, is a sincere desire to do what is right?"[1]

Like the editor of the *Newsletter of the Association for Improvements in the Maternity Services* cited above, we think that there is enormous sincerity within the "opposing factions" engaged in the debate about childbirth and the perinatal health services. As individual co-authors of this paper we obviously each have somewhat different allegiances and perspectives. We are, however, united in a belief that there has been a dangerous tendency to oversimplify the issues in the debate by careless, and in certain cases biased, use of the available information. In this paper we review the succession of recent attacks on the perinatal health services, offer some views on the legitimacy of the criticisms made, and conclude by selecting some issues that we think merit wider discussion than they have so far received.

Attacks on the perinatal health services

Challenges to the perinatal health services over the past five years have come from three different directions. The first arose from disquiet among users of the services concerning some of the attitudes and practices that had come to characterise modern perinatal medicine.[2] In the ensuing controversy policies for active induction have been a particular target for adverse comment, but the debate is concerned with very much more fundamental issues than this implies. The second major attack came in 1976 from government itself: a consultative document[3] singled out maternity services for reduced funding, using the falling birth rate as a rationale for this recommendation. The most recent challenge to our perinatal health services has reflected a belief that they are of poorer quality than those in some other countries and that we are paying for this inferiority in terms of both avoidable perinatal deaths and preventable handicap in survivors.[4 5]

Professional response to these three challenges has varied. Although a sense of outrage was detectable among some of the early reactions to the consumer challenge,[6 7] there is now a growing willingness to try to understand and react helpfully to the views of those using the services, and to assess more carefully the balance of beneficial and hazardous effects of the various forms of intervention used in perinatal practice.[8 9] The more recent contention that Britain's perinatal services are failing to prevent avoidable death and handicap might have been expected to result in a more determined closing of clinical ranks. But in fact clinicians engaged in defending their services against cuts have used the claims of the "prevention-of-avoidable-handicap" lobbyists to argue for increased investment in the perinatal services on the "sound economic grounds of cost-effectiveness."[10 11]

These debates about the services we provide for mothers and their unborn and newborn children reflect, in part, the unique status of childbirth as a social and cultural phenomenon but also some specific characteristics of the 1970s. In the past ten years we have experienced the worst economic depression since the 1930s, and this has led to the closer scrutiny of all publicly funded services. Consumerism has established itself as a significant force. The emergence of a women's liberation movement has provided a platform for the demand that more control over the management of reproduction be vested with women themselves, and this has been part of a widespread challenge of professional authority—both within and outside medicine.

Seduction by simple explanations and simpler solutions

We wish first to consider just how information has been abused in the various debates about services for mothers and infants because we are concerned by the extent to which unsatisfactorily substantiated claims may have been accepted both by those working in the services and by others. This lack of critical analysis is particularly worrying if it leads to changes in practice that do not cater effectively for the needs of those using and working in the perinatal health services. For example, during the past two years it has been widely proposed[12] that financial incentives for women to attend antenatal clinics early and regularly throughout pregnancy would lead to reduced mortality and handicap. Early and regular attendance for antenatal care is of undoubted value for certain women and their babies, although it has not been established that all pregnant women derive benefit from such care.[13] What, however, is the basis for proposing that financial incentives are the most appropriate way of securing increased attendance? At this point the French card is usually played: "Ten years ago the rate of perinatal death and handicap in France was 25% higher than that in Britain; now it is 15% lower. . . . One notable feature of the French system of care is the use of financial incentives to encourage pregnant women to seek care early and regularly. . . . We should therefore give urgent consideration to implementing this approach to lowering perinatal mortality and handicap in Britain."

But let us look more closely at the facts:

(1) French commentators are not clear why there has been such a dramatic recent fall in the risk of perinatal death in France.[14 15]

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(2) Whatever the reasons, these are unlikely to include financial incentives, which were introduced more than 30 years ago.[15]

(3) In France in 1976 40% of pregnant women attended for antenatal care on fewer than five occasions.[16] The proportion of British women attending so infrequently has probably been 5% or less for at least 20 years.[17]

(4) The interpretation of French neonatal mortality statistics has been problematic because of the existence of a category denoted "death before registration."[18]

(5) There is evidence that the proportion of perinatal deaths from unavoidable causes is higher in Britain than France (thus the incidence of anencephaly in 3-4 per 1000 in Britain and 0·5 per 1000 in France).[19]

(6) There are no statistics describing trends in the incidence of handicap in France.

(7) The maternal death rate is twice as high in France as it is in England and Wales.[20]

These considerations point to the dangers of using crude mortality statistics to assess the quality of perinatal health care in different countries. Exactly the same reservations apply to suggestions that Rochdale and Calderdale should look to Oxford and Suffolk for lessons in how to run their health services.

Of the various ways in which data has been abused in recent debates, three specific types of abuse are misleading. The first is the use of crude mortality statistics as if they accurately reflect both the quality of perinatal care and the prevalence of handicap (usually undefined). Thus populations with relatively high perinatal death rates are deemed to be in receipt of poor quality care and to have a relatively high prevalence of handicapped children. This ignores, among other things, the fact that some causes of perinatal death are far more likely than others to be influenced by the quality of perinatal care.[21] Similarly, there is no straightforward relation between crude perinatal death rates and the prevalence of handicap among survivors (J A Macfarlane's report on the Oxford cerebral palsy study given at the International Cerebral Palsy Meeting, Dublin, October, 1979). "Handicap" is rarely defined by those who have used the word in the context of criticising the perinatal health services; but the best available evidence suggests that the incidence of, for example, cerebral palsy (one broad category comprising several syndromes with different aetiologies) has not declined consistently in the same way as death rates.[22]

A second and another worrying feature of the debate has been a tendency to propose oversimple solutions. Thus it has been proposed that improvements in the quality of our services should be sought through devoting attention to the size of our hospitals; by introducing financial incentives for antenatal care; by achieving universal hospital confinement; through the routine use of ultrasound or intensive intrapartum fetal monitoring, the wider use of corticosteroid and beta-mimetic drugs in the management of preterm labour, the treatment of infections during pregnancy, the intensification of neonatal care, and so on. In the face of uncertainty about what really is wrong there is an understandable tendency for people to propose easily identified "solutions"—usually with a bureaucratic or technological emphasis. This tendency is not specific to perinatal care. The very normality of most childbearing women, however, demands that we should be particularly scrupulous in protecting them from the adverse effects of policies that are formulated through concern for the minority who experience problems.

Our third and last general concern relates to the often cavalier disregard for accepted methods of judging associations to be causally related.[23]

Pointers to better perinatal health services

Despite these regrettable features, the debate about perinatal care has promoted some thoughtful discussion.[24] Certain pointers to better services have emerged, but for various reasons these do not appear to have enjoyed the prominence they deserve. One of the reasons for this is our dependence on crude death rates as the only generally available measure for judging the outcome of pregnancy. As we have indicated earlier, these statistics are not sensitive measures of the quality of services. Indeed, it is by analysing them that we are able to conclude that health services, as such, have a relatively marginal influence on this particular measure of perinatal health.

This fact is important because it sets current concern about the quality of perinatal care in a wider perspective. The most powerful "determinants" of poor outcome of pregnancy seem to lie outside the traditional scope of the health services.[25] They are related to mothers' socioeconomic circumstances, and probably include such factors as diet, vulnerability to infections, and stress. We believe that a more general acknowledgment of this fact is important because those whose main interest lies in the health services should also be influential promoters of improvements in the wider environment in which childbearing occurs. Thus, for example, discouragement of smoking in the context of antenatal care should be matched by efforts to influence the commercial and social pressures that encourage people to start and continue to smoke; skilled intensive care of the immature baby should be accompanied by concern to improve the environment in which the baby was conceived and to which it will return.

Sometimes these broad objectives may be pursued by relatively discrete means—control of tobacco promotion, improving access to family planning and genetic counselling services, and increasing maternity grants and family allowances. There are, however, no straightforward solutions to some of the more fundamental problems—impoverished social circumstances, ignorance of childbearing and child-rearing, the low social status accorded to mothers in our society, and inadequate social support for women coping with expectations that they should combine successfully the roles of spouse, charwoman, mother, and wage-earner. These problems are not amenable to trite solutions. But their undoubted importance in contributing to an unsatisfactory outcome of pregnancy (in both the narrowest and broadest senses) is good reason for trying to exploit opportunities to improve matters—whether this be at the level of the individual family or the community at large.

Likewise, *within* the perinatal health services some of the pointers to improved care are circumscribed while others are less tangible. Clearly, care must be available to women sufficiently early in pregnancy to permit the option of termination if this seems a preferable alternative to that of allowing the pregnancy to proceed; pregnant women with conditions such as diabetes, renal disease, and hypertension must receive the skilled attention that such conditions demand; newborn infants should be kept warm, assisted to establish respiration if they fail to do so spontaneously, and have access to specialist care should they need it.

But allusion to these and other specific proposals has often been marked by emphasis on the technology associated with clinical care. Rarely has it been emphasised that technological aspects of care are probably of minor importance when compared with the clinical skills of the individual midwives, doctors, and nurses responsible for providing care to mothers and babies. Clinical experience in identifying true pathology in a predominantly healthy population; clinical judgment concerning the most appropriate course of action for each case identified; clinical skill in implementing the management selected: these aspects of clinical expertise seem to have attracted little explicit attention in the debate about the quality of perinatal care. It is true that they are difficult attributes to study systematically,[26] yet it seems reasonable to assume that the quality of care is critically dependent on them. Maintaining and using this body of clinical skill efficiently must always remain one of the keys to a good service. Yet, although more trained staff were available to look after less women in 1970 compared with 1946, the proportion of women delivered by trained personnel actually decreased over this period.[27] There are no easy answers to this problem; but solutions are likely to be found

by directing more attention to career structures in obstetrics and paediatrics, reducing "wastage" among midwives and nurses, and ensuring that the skills acquired by professionals are appropriately deployed.

But if clinical skill in a technical sense is one of the essential ingredients of perinatal care of high quality, so also is that other component of good clinical care—the ability of a professional worker to understand and take into account the views of individual clients. The current debate was precipitated by inadequate recognition among professionals that parturient women are not simply passive recipients of maternity care. All the available information points to pronounced discrepancies between the needs and expectations of those who provide and those who use the perinatal health services.[28-33] Clinicians see reproduction as a medical and potentially pathological process, the success of which is to be measured in terms of perinatal mortality rates and guaranteed by the surveillance of professional experts. Mothers are more inclined to regard it as a normal part of social and personal life and to judge success in terms of their own satisfaction with the experience and the impact it has on their lives. These different perspectives underlie many of the frequently mentioned criticisms of perinatal care: being treated like depersonalised "objects" on an assembly line during pregnancy, labour, delivery, and the puerperium; having to wait too long to be seen by doctors; not having the opportunity to develop a relationship with one or two service providers; receiving inconsistent advice; being unable to ask questions or receive sufficient information; being subjected to "unnecessary" interventions during pregnancy, labour, and delivery; being separated from the baby as a result of inflexible hospital regulations; and receiving insufficient sympathy with social and emotional aspects of childbearing, especially those relating to family life.

Failure to take account of these objections is most relevantly illustrated by considering the group of women that the DHSS and others are most anxious to "reach"—the late attenders for antenatal care. Late attendance is more frequent among working class women and at the extremes of maternal age and parity. It is also associated, however, with distance from the clinic, the use of a lay "referral" (or "consultancy") network among female relatives, perception of pregnancy as a normal life event, absence of a desire to obtain medical confirmation of pregnancy, and mistrust of medical skill[34 35] (H Graham and L McKee in a report on a Health Education Council project concerned with women's experiences of pregnancy, childbirth, and the first six months after birth. Vol 4, medical care). A further crucial consideration is delay instituted by the services themselves[36] (A Oakley, unpublished data). The supposition that either more information or financial inducements will change this and the behaviour of the women concerned is an unfounded and oversimplistic model of human action. Yet the concept of the mother's responsibility for late attendance and other "non-medical" maternal behaviour is often subtly or explicitly transformed into one of maternal culpability.[37] Put crudely, the argument often seems to be that babies die because their mothers knowingly and wilfully put them at risk by smoking too much, choosing the wrong diet, refusing to attend for antenatal care, and even stubbornly holding out for confinement in an unsuitable place—the home. The evidence points in a quite contrary direction: the behaviour of women as maternity patients or as the mothers of child patients is, like that of patients in general, often determined by social and economic conditions over which they as individuals have little control, although they recognise their responsibility to their baby.

A capacity to appreciate these issues and their impact on the individual family is just as essential an element of good clinical care as the more technical abilities referred to earlier. Indeed, one of the possible implications of the association observed between stress and adverse outcomes of pregnancy[38 39] is that efforts to mitigate stress may influence traditional measures of perinatal outcome. Yet, whether or not this proves possible, surely there are already adequate humanitarian grounds for ensuring that childbearing women receive emotional support both within and outside the services. It was Ballantyne (generally acknowledged as the founder of antenatal care in Britain) who suggested that "the removal of anxiety and dread from the minds of expectant, parturient, and puerperal patients" should be the primary objective of those caring for childbearing women.[40 41] Furthermore, efforts to engender the self-confidence of a woman in her own abilities during this crucial experience are likely to pay dividends far beyond the immediate context of childbirth.

We believe that the quality of the perinatal health services is determined principally by the extent to which individual professional workers combine compassion with clinical expertise in their dealings with individual women and their families. Our "immodest proposal" boils down to a plea for wider explicit acknowledgment of this proposition and thus of the inherent complexity of fostering improvements in the quality of personal care available to childbearing women.

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Letter from . . . Chicago

Killing the golfing goose

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Whatever one may think of lawyers in the context of malpractice (which probably is not very much), it is to their everlasting credit that the case of the murdered goose was settled out of court. For this regrettable incident, taking place not in the wilds of Georgia (unlike the attack on President Carter by a rabbit) but right on the Congressional golf course, almost precipitated an international crisis. Some 30 000 Iranian students threatened to demonstrate on the White House lawn. Mr Andrew Young nearly abandoned the Palestine cause for the anserine cause. Even the Euthanasia Society doubted that the doctor had merely acted out of mercy in putting the injured bird out of its misery. Environmentalists, while admitting that honking geese were a nuisance, thought that Concordes and noisy 'garbage trucks more seriously disturbed the golfers' concentration. The State Department worried that, since Canadian geese were protected under the Migratory Bird Treaty Act, bludgeoning the bird with a golf stick and wringing its neck could threaten relations with our Northern neighbour. And the anti-doctor lobby declared that a $500 fine was no deterrent for future unnecessary operations of a similar kind.

Major and minor surgery

Yet killing geese out of season is merely one example of the recent spate of unusual operations. In Chicago a 29-year-old rock singer underwent plastic surgery to change his face into the likeness of the late Elvis Presley. Sex-change operations, though recently discontinued at Johns Hopkins, are still performed in other parts of the country. A strange young man used mirrors, retractors, and a perfect aseptic technique in an attempt to remove his adrenals, only two months after castrating himself to control his sexual and aggressive feelings; he might have successfully finished the operation were it not for the pain caused by retracting the liver. In California, surgeons removed from a young woman a 91 kg benign ovarian tumour measuring 0·9 metres in diameter. But a cautious young navy doctor, who refused to go to sea because he felt unqualified to operate after only one year's training in surgery, was sentenced to six months hard labour and a substantial fine by a military judge; an American Medical Association study found that the incidence of unjustified surgery in the US was less than 1%, not 17% as reported; and the insurance companies hope to save millions of dollars by promoting ambulatory surgery instead of having patients admitted for myringotomy, tonsillectomy, dilatation and curettage, laparoscopy with tubal ligation, excision of breast masses, circumcision, herniorrhaphy, and vasectomy.

To turn now to major surgery, President Carter last year cut off six of his cabinet ministers, including Secretary of Health, Education, and Welfare (HEW) Joseph Califano, whom he replaced with Mrs Patricia Harris, a liberal lady who rather than fool around with dangerous cigarettes will merely address herself to larger social issues. Extending his operative field, the President then carried out his promise to the unions by amputating the E out of HEW and establishing a new cabinet-level department of education—thereby increasing the cost of government bureaucracy as well as injecting Federal politics into a function that was largely under State and municipal control. Congress joined in the surgical foray by again cutting funds for abortions, in the process holding up the pay of all its Federal employees. The government is also slicing at the budgets of the Veterans Administration hospitals; local councils are chopping at the budgets of the already perilously compromised municipal hospitals; Senator Edward Kennedy cut the Gordian knot and entered the Presidential race; and the Federal Trade Commission, still busily trying to obliterate differences between trades and professions by promoting competition, advertising, and other commercial practices, is now under criticism for excessive regulatory zeal and may have its wings clipped by Congressional legislation.

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